their supervision. The training of other levels of health workers regarding this level would assist them in community recognition and functioning within the role they are intended.

10) Drug Supply- This is a very complex issue and important to the health workers within Afghanistan. The recurrent complaint that the supply to a worker is not sufficient is simply a symptom. The actual root problem beneath the complaint can be quite variable. It is important that in each instance the following

to the health workers.

c) Increased patient load relative to the supplies provided. This may also relate to an increase in a certain type of health problem resulting in specific drugs being used up more quickly.

It is important to begin defining the specific problems rather than simply increasing the amount of drugs moving within Afghanistan. The implications are significant both in terms of economics and sustainability but to the patients who are at risk from poor drug utilization by health workers.

ANNEXES:

I. Maps
- Ia. Kandahar
- Ib. Arghandab
- Ic. Arghestan
- Id. Dand
- Ie. Maiwand and Panjwai

II. Summary of compiled health Problems as seen by direct patient visits in Arghestan.

III. Specific health workers and facilities as sorted by district Kandahar.
- IIIa) Description/Introduction to HIS information.
- IIIb) Revised HIS listing of health facilities in Kandahar.
- IIIc) Listing of health facilities visited in Kandahar sorted by district which were not included in the main body of the report.

IV. Recommendations of the Arghestan shura regarding the UN and assistance in their area.

V. Pictures from WHO team.

a)

MAP OF DISTRICT ARGHANDAB

SHAH WALIKOT
DE SYAHSANG GHAR
SHAH AGHA
BOLAN GHAR
ZARO GHAR
RUINS
ZARE DASHTA
Karez Mir Hazar
RUINS
MAIWAND
Kaza Ghundey
Deh Sawz
Senzaray
PANJWAI
DAND
DAMAN
Nagahan
Koh ak
Loy Manara
Charqulba i ulya
Pire Paymal
Jazan
Shuyene Wusta
Babur
Mazra i Abba
Gul Kalacha
Maranjar
Sarde Ulya
De Maranjar GHAR
Nurzayi Karez
Mansurabad
Langar

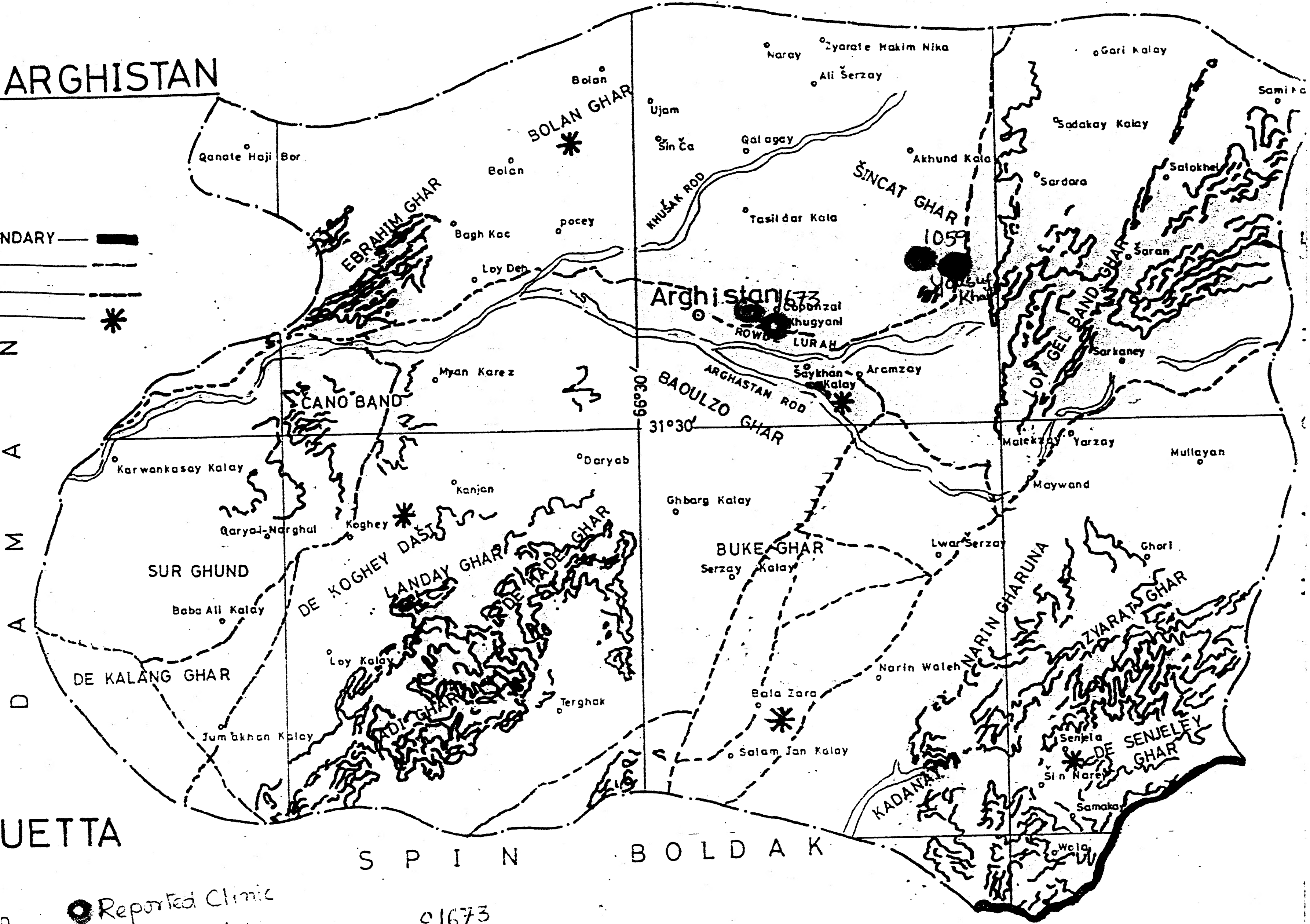
LEGEND
BOUNDARY DISTRICT
CANAL
MUD ROAD
RIVER
VILLAGE

UNIDATA-QTA

PAVED ROAD
CENTER OF DISTRICT

O ARGHENDAB
REPORTED CLINIC
VISITED CLINIC

01799 — (1)
01024 — (2)
01002 — (3)
01183 — (4)
01636 — (5)
01011 — (6)
01394 — (7)
01637 — (8)



MAP OF ARGHISTAN
LEGEND
INTERNATIONAL BOUNDARY
DISTRECT BOUNDARY
ROAD MUD
MINE FIELD
RIVER
N
ALE 1:250·000
Z A B O L
D A M A N
S P I N B O L D A K
Qanate Haji Bor
Bolan
Bolan
BOLAN GHAR
EBRAHIM GHAR
Bagh Kac
pocey
Loy Deh
Ujam
Sin Ca
Qal agay
KHUŠAK ROD
Naray
Zyarate Hakim Nika
Ali Šerzay
Tasildar Kala
Akhund Kala
ŠINCAT GHAR
1059
Yousuf Khel
Arghistan
673
Khugyani
ROWDE LURAH
Saykhan Kalay
Aramzay
ARGHASTAN ROD
BAOULZO GHAR
66°30
31°30
Gari Kalay
Sadakay Kalay
Sardara
Salokhel
Saran
LOY GEL BAND GHAR
Sarkaney
Samika
Malekzay
Yarzay
Mullayan
Maywand
Myan Karez
CANO BAND
Karwankasay Kalay
Daryab
Kanjan
Qaryai-Narghal
Koghey
SUR GHUND
DE KOGHEY DAŠT
LANDAY GHAR
DE KADE GHAR
Baba Ali Kalay
DE KALANG GHAR
Loy Kalay
Terghak
Jum'akhan Kalay
Ghbarg Kalay
BUKE GHAR
Serzay Kalay
Lwar Serzay
Ghori
NARIN GHARUNA
ZYARAT GHAR
Narin Waleh
Bala Zara
Salam Jan Kalay
Senjela
DE SENJELEY GHAR
Sin Narey
Samakay
KADANAI
Wala
UNIDATA QUETTA
DATE APRIL: 1990
ENG SALEH MOHAMMAD
Reported Clinic
visited Clinic
c1673
c1059

Dand

65 30

LEGEND

Highways	Province Capital
Other Roads	Woloswali Centre
Cart Tracks	Alaqadari Centre
Int'l Border	Alternate Centre
Province Border	Other Towns
District Border	

Map by: UNIDATA / Mapping Service (8/90)

Baba Vali Saheb

Safdar Kalay

QANDAHAR
2401

Hajji Aziz

Daman

Nakhouni

DAND
2402

Mahal

Kuchny Bala Karz

Lowy Bala Karz

Gondigan

Naseran

Kolchehabad

Sher Sorkh

Sabornow Kalacha

Waidkan

Zaker-e-Sharif

Zalakhan

Bazar-e Panjvai

Belanday

Baiaday

31 30

Lowy Karizak

Mard Kala

Rawanay

Molla Kuchay Jabar Kalay

Khvosh'Ab

Teymur Kalay

Deh Gholaman

Ruhabad

Kalantar Kalay

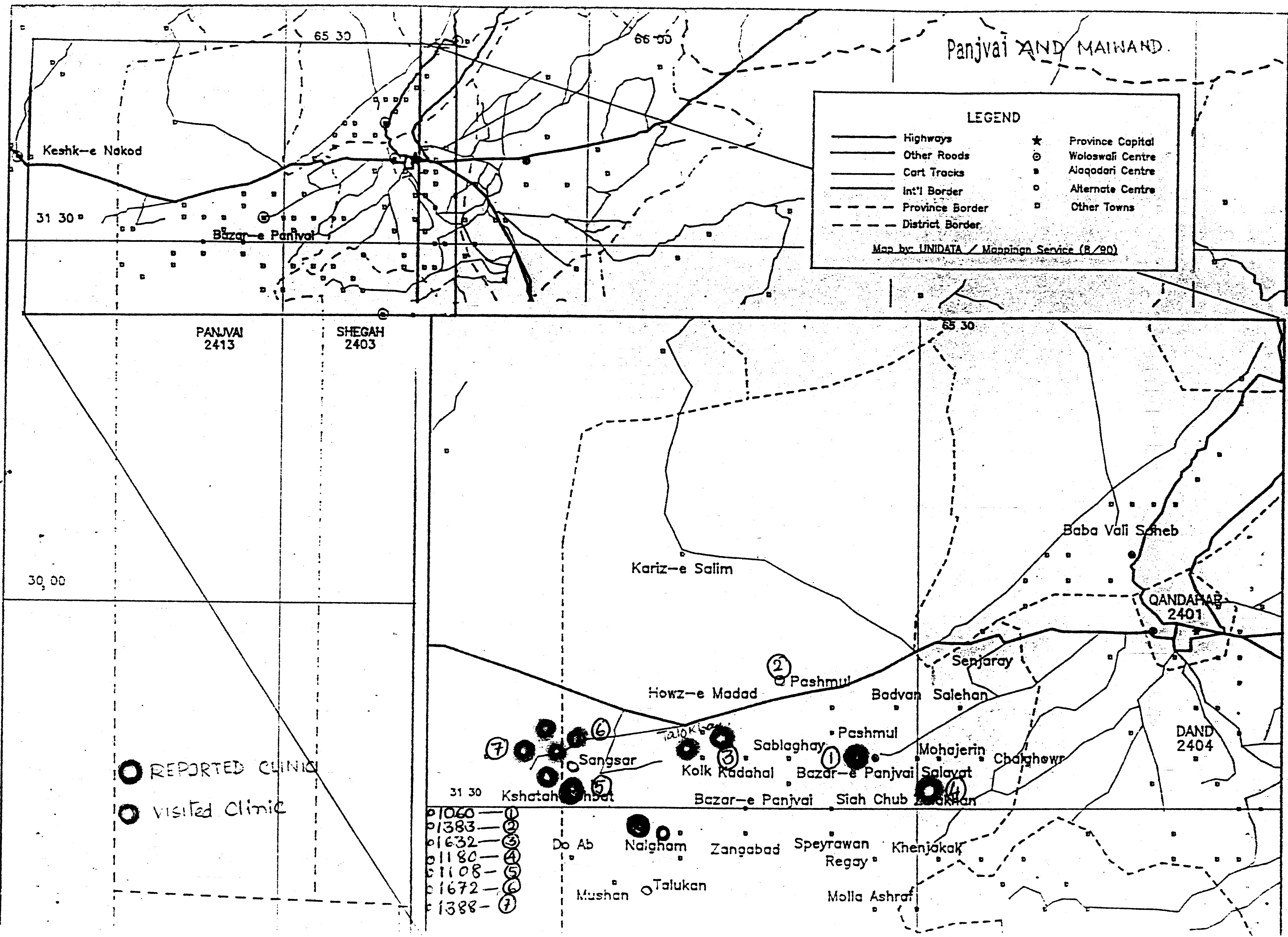
Shegah

Shegah

013 — (1)
091 — (2)
c 1629 — (3)
p 1638 — (4)
c 1629 — (5)
p 1796 — (6)

Reported Clinic

Visited Clinic



Panjvai AND MAIWAND.
LEGEND
Highways
Other Roads
Cart Tracks
Int'l Border
Province Border
District Border
Province Capital
Woloswali Centre
Alaqadari Centre
Alternate Centre
Other Towns
Map by: UNIDATA / Mapping Service (8/90)
65 30
65 00
31 30
30 00
Keshk-e Nakod
Bazar-e Panjvai
PANJVAI
2413
SHEGAH
2403
QANDAHAR
2401
DAND
2404
Baba Vali Saheb
Kariz-e Salim
Senjaray
Pashmul
Howz-e Madad
Bodvan
Salehan
Sablaghay
Mohajerin
Chalghowr
Sangsar
Kolk Kadahal
Salavat
Kshatah
Siah Chub
Do Ab
Nalgham
Zangabad
Speyrawan
Regay
Khenjakak
Mushan
Talukan
Molla Ashraf
Talokan
1060—1
1383—2
1632—3
1180—4
1108—5
1672—6
1388—7
REPORTED CLINIC
Visited Clinic

ANNEX II: SUMMARY OF COMPILED HEALTH PROBLEMS AS SEEN IN SMU CLINIC IN ARGHESTAN.

Over a period of 19 days a total of 507 patients were seen at the SMU clinic in Arghestan. This resulted in an average of 25 patients per day. Upon examination of the patient records the following patterns were revealed. It is noteworthy that this clinic was established and staffed by a WHO/UNV expatriate physician. These facts would influence the data gathered in many ways.

1. Of total patients 71 patients were female = 14.11%

2. 0-5 yrs = 70 patients with 41.42% female and 58.57% male.

3. 6-15 yrs = 118 patients with 11.86% female and 88.1% male.

4. 16 and above yrs = 315 patients with 8.9% female and 91.1% male.

In each age range the common pathology diagnosed during this period was tabulated. Counting was taken to reach a total of at least 75%. This number was chosen in order to account for the goal of health training programs to insure that graduates are capable of handing disease categories (prevention, diagnosis and treatment) of the most common diseases. In certain cases the chief complaint is stated rather than the diagnosis.

Common Diseases by diagnosis:

<u>0-5 Yrs</u>

1) Diarrhea = 32.85%
2) Common Cold = 12.85%
3) Scabies = 12.85%
4) Measles = 14.28%
5) Helminthiasis = 8.5%*
6) Suppurative otitis media = 5.7%

<u>6-15 Yrs</u>

1) Helminthiasis = 20.33%*
2) Common Cold = 10.2%
3) Scabies = 9.32%
4) Diarrhea = 6.77%
5) Conjunctivitis = 5.08%
6) Suppurative Otitis media = 5.93%
7) Arthralgia = 4.23%
8) Tonsillitis = 2.54%
9) Dysentery = 5.1%
10) Abscess = 3.3%
11) Generalized weakness = 2.54%
12) Erysipelas = 2.54%
13) Malaria = 1.69%

16 Yrs or greater

1) Common Cold = 13.3%
2) Helminthiasis = 12.4%*
3) Arthralgia = 8.57%
4) Indigestion = 8.10%
5) Generalized weakness = 7.69%
6) Scabies = 5.7%
7) Hypertension = 4.4%
8) Backache = 4.76%
9) Diarrhea = 3.17%5
10) Minor injury = 3.17
11) Epistaxis = 2.85%
12) Conjunctivitis = 2.2%
13) Musculoskeletal leg pain = 2.2%
14) Gastritis = 1.9%
15) Suppurative Otitis media = 1.58%
16) Abscess = 1.26%
17) Bronchial Asthma = 0.95%
18) Oral infection or other pain = 0.95%

*= Diagnosis by clinical signs and symptoms (no laboratory available).

It is anticipated that there would be seasonal variation in many of these categories.

ANNEX IIIa)

INTRODUCTION TO WHO-HIS DATABASE

This Health information System as maintained by WHO represents an ongoing effort to account and define the available health resources within Afghanistan. The sources of information are numerous, including on-site reports within Afghanistan, reports by NGO's listing their resources, Kabul Government reports, and many others.

The importance of this information for planning and presentation purposes cannot be overstated. The maps, reports and graphs available upon request from WHO have been widely used both locally and internationally. The information must however, be understood in context. The data provided represents the effort of many individuals over many years. Special appreciation to the NGO's, USAID and UNIDATA mapping service have allowed this information to be used and presented more completely recently. However, for all agencies working within Afghanistan, it is recognized to be a fluid and unstable situation that is very difficult to monitor and assess. The integrity of the information is the goal of WHO but there are many constraints. The most significant constraint is the lack of access to the sites where resources are reported. It is hoped that with time this will improve both for the integrity of the actual programs as well as the information available about them.

In reading any report by the HIS system please note:

1) Facility ID numbers are given by WHO to specific health facilities. These numbers match the numbers printed on the maps. Within each facility there are staff assigned individual ID numbers which are also maintained in the database.

2) The type or level of facility is assigned based on community consensus as defined recently in joint meetings between the UN, NGO's and AIG. The database assignment of the facility level is in process and in many places remains incomplete until enough information is available to judge.

3) Services provided are usually stated after a monitoring visit has been completed to the area.

4) Spellings of provinces, districts and to the extent possible, villages have been standardized with USAID and UNIDATA mapping.

5) The column titled monitor relates to the most recent monitor by organization and the date the mission was on-site. It is notable that in many sites other (previous) reports are available via WHO.

For any person interested a request to WHO regarding specific facilities, health workers, or other details is welcomed. The HIS staff appreciate questions and further information.

[illegible]	[illegible]	ProgID	Type	Level	Services	Province	District	Village	Monitor	Mon-Date	Found	Activ
[illegible]	[illegible]	1276	C	-Ø-	-Ø-	Kandahar	Arghandab	ARGHANDAB	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	0214	M	MOBILE	-Ø-	Kandahar	Arghandab	CHARBAGH	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	OPD	Kandahar	Arghandab	CHARGHULBA	WHO	24/07/90	Y	Y
[illegible]	[illegible]	1077	C	-Ø-	OPD	Kandahar	Arghandab	CHARGHULBA	WHO	19/05/90	Y	Y
[illegible]	[illegible]	5276	C	-Ø-	OPD	Kandahar	Arghandab	CHARGHULBA	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	4141	C	-Ø-	OPD	Kandahar	Arghandab	KHWAJA MULK	WHO	21/05/90	Y	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	OPD	Kandahar	Arghandab	KHWAJA MULK	WHO	15/07/90	Y	Y
[illegible]	[illegible]	2277	C	-Ø-	OPD,DENT,LAB	Kandahar	Arghandab	KHWAJA MULK	WHO	17/05/90	Y	Y
[illegible]	[illegible]	5025	C	-Ø-	OPD	Kandahar	Arghandab	KOWAK	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	0100	C	C-2	-Ø-	Kandahar	Arghandab	SARDI BAGH	WHO	20/05/90	Y	Y
[illegible]	[illegible]	-Ø-	H	H-3	-Ø-	Kandahar	Arghandab	-Ø-	WHO	25/07/90	N	N
[illegible]	[illegible]	5003	C	-Ø-	OPD	Kandahar	Arghandab	-Ø-	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	0215	M	MOBILE	OPD	Kandahar	Arghistan	KHOUGIANI	WHO	07/06/90	Y	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	OPD,MOBILE	Kandahar	Arghistan	YOUSUF KHAIL	WHO	25/07/90	Y	Y
[illegible]	[illegible]	-Ø-	H	H-1	-Ø-	Kandahar	Dand	CITY	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2216	M	MOBILE	-Ø-	Kandahar	Dand	IRAZAI	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2013	M	MOBILE	-Ø-	Kandahar	Dand	KAHALAJAT	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2217	M	MOBILE	-Ø-	Kandahar	Dand	SHERI SURKH	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	H	H-1	-Ø-	Kandahar	Kandahar	CITY	-Ø-	-Ø-	-	-
[illegible]	[illegible]	-Ø-	H	H-1	-Ø-	Kandahar	Kandahar	CITY	-Ø-	-Ø-	-	-
[illegible]	[illegible]	2226	C	C-2	-Ø-	Kandahar	Khakrez	ZEAL ABAD	CMC	-Ø-	-	Y
[illegible]	[illegible]	2211	C	C-2	LAB+DENT	Kandahar	Maruf	MANA	CMC	21/06/89	Y	Y
[illegible]	[illegible]	5033	C	-Ø-	OPD	Kandahar	Maruf	PIRZAIE	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Maruf	-Ø-	CMC	-Ø-	-	Y
[illegible]	[illegible]	1216	C	C-2	-Ø-	Kandahar	Maywand	NALGHAN	CMC	-Ø-	N	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Maywand	SANGE HESAR	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2219	M	MOBILE	-Ø-	Kandahar	Maywand	SANGE HESAR	CMC	04/04/89	Y	Y
[illegible]	[illegible]	5251	C	-Ø-	OPD	Kandahar	Maywand	SANGE HESAR	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Maywand	-Ø-	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	OPD,VAC,INPT,LAB	Kandahar	Panjwaie	BAZAAR	WHO	25/07/90	Y	Y
[illegible]	[illegible]	2225	H	H-3	LAB+DENT	Kandahar	Panjwaie	NAKHOUNI	CMC	-Ø-	Y	Y
[illegible]	[illegible]	5288	C	-Ø-	OPD	Kandahar	Panjwaie	PASHMOL	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Panjwaie	TALOKAN	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2213	M	MOBILE	-Ø-	Kandahar	Panjwaie	[illegible]	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	[illegible]	C	-Ø-	-Ø-	Kandahar	Panjwaie	[illegible]	CMC	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Panjwaie	-Ø-	CMC	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Panjwaie	-Ø-	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	2274	C	C-2	OPD, DENT	Kandahar	Shah Wali Ko	SUZNI	-Ø-	-Ø-	-	Y
[illegible]	[illegible]	[illegible]	C	-Ø-	OPD	Kandahar	Shah Wali Ko	SUINI	CMC	-Ø-	-	Y
[illegible]	[illegible]	-Ø-	C	-Ø-	-Ø-	Kandahar	Shorabak	-Ø-	CMC	04/04/89	-	Y

[illegible] Number of Facilities in Report: 40

KANDAHAR

The province of Kandahar lies north of Quetta division of Pakistan. It is bordered on the east and north-east by Zabul province, on the north by the Uruzgan province and in the west by Helmand. A south-west SMU (Salam Mobile Unit) was based in Arghestan (one district of Kandahar) at the end of June 1990.

General background

The Kandahar SMU started its mission from 27 May 1990. WHO in collaboration with other UN agencies took part in this mission on 4 June 1990. The district covered during this mission included Arghestan and Arghandab then returned back on 1 July 1990. In August another joint UN mission, with WHO participation, set out to visit the districts of Punjwai, Maiwand and Dand. This mission lasted for 15 days (22 July to 31 July and 11 August to 18 August 1990). This report describes the combined results of these missions. For more general information refer to the UNOCA reports for Kandahar.

Terms of Reference

The involvement of WHO in the UN missions within Kandahar included the following terms of reference:

1. Verification of data in WHO HIS Database about Health facilities and Health workers. Description of health resources not listed in the database by WHO questionnaire.

2. Assessment of community motivation and perception of needs through meetings with the Shura and health workers.

3. Assessment and definition of needs for further health inputs into the target area. Evaluation of potential and proposed funding via WHO.

4. Monitoring of WHO funded projects within target area.

5. Assist in the set up SMU.

Map

Refer to attached maps annex Ia-Ie- Kandahar and each district.

Routes

Between the border from Chaman Pakistan to Spinboldek within Afghanistan the distance is approximately 5 kilometers and the road

ANNEX IIIc)

Arghestan

1. MCI mobile clinic. HIS # 1673.

Arghandab

1. The ICRC first-aid post in Arghandab is staffed with physicians and surgeons. The post is mandated to provide first-aid care to war casualties including mine injuries. They refer the patients to Quetta through their own ambulances.
There are two ICRC ambulances with transport to Balochistan via non-paved roads.

3. One Arab (LDI) clinic in Khujamal (HIS #1177) is used as an OPD but receives war causalities/ emergency patients and refers to modernized hospitals after first-aid treatment in Quetta by their own ambulance.

4. One IMC clinic in Khujmul Arghandab (HIS #1024) is small (three rooms) but situated in well communicated and well populated place. Supplies are regular, equipment is good and well maintained. Water supply comes from canal and no latrine.
This clinic will be phased out and the worker will be moving to the IMC facility #1183.

5. MSH clinic (facility #1637) in big Mumara in Arghandab.

It is under and within the influence of Mujahideen Camp and does not interact with the civilian population.
This one room "clinic" is run by basic health workers. The person interviewed stated that on a rotating basis every other month a 4th year medical student comes to work in the clinic. Report that they have another clinic location in Basabad mujahideen post where they also go to provide health services every other month. During our visit there was no equipment and no supply of medicine.

6. MCI clinic in Sardibagh, Arghandab (HIS #1011)

This clinic is reportedly run by a fourth year Kabul medical student who joined this facility 5 months ago (He was not present during the teams visit). Other staff include 2 midlevel workers. The facility consists of one room within a mujahedeen camp. There were very minimal drugs, no equipment. When the staff was questioned on basic treatment protocols for their level there was very poor ability to respond. The WHO team recommends the need for further training.
The clinic is situated in a very accessible place and near civilian population but this clinic only serves the interest of Mujahideen.
This clinic was recently monitored in detail by a private consultant of MCI. Report available from MCI on request.

Panjwai

1. One military based clinic in Punjwai previously supported and supplied by SCA (now reportedly they have withdrawn their support- was HIS #1383). Currently they state they receive drugs and equipment from MCI and Mujahideen sources. During the visit there were only minimal drugs within the clinic. They treat only Mujahideen. The staff of two or three people provided drugs based on no physical examination.

Dand

1. MSH supported clinic Shersak village of Dand Kandahar.

This facility was full of weapons and ammunition with a few drugs. There was one man present interviewed who presented his knowledge very poorly on questioning.
It was the WHO teams belief that the combination of weapons and the health equipment was inappropriate.

Maiwand

1. MSH supported clinic (HIS #1179) in Neilgam, Maiwand.

One single room with one health worker trained by MSH as BHW. The clinic is near mujahideen camp only.

2. MSH facility in Sangishar, Maiwand: Staffed by BHW's.

ANNEX IV:

Recommendations of Arghestan Shura Regarding UN Assistance:

1. This Shura and people as a whole want to participate in any development works of WHO.

2. Drugs and Alcohol should not be used by any of these people.

3. There should be a place for praying within the SMU base.

4. WHO in Arghestan should inform either the Shura or the Health sub-committee prior to undertaking any activities. WHO or any agency should not deal with any leader separately. The Health sub-committee was established to simplify the working relationship of the Shura with WHO.

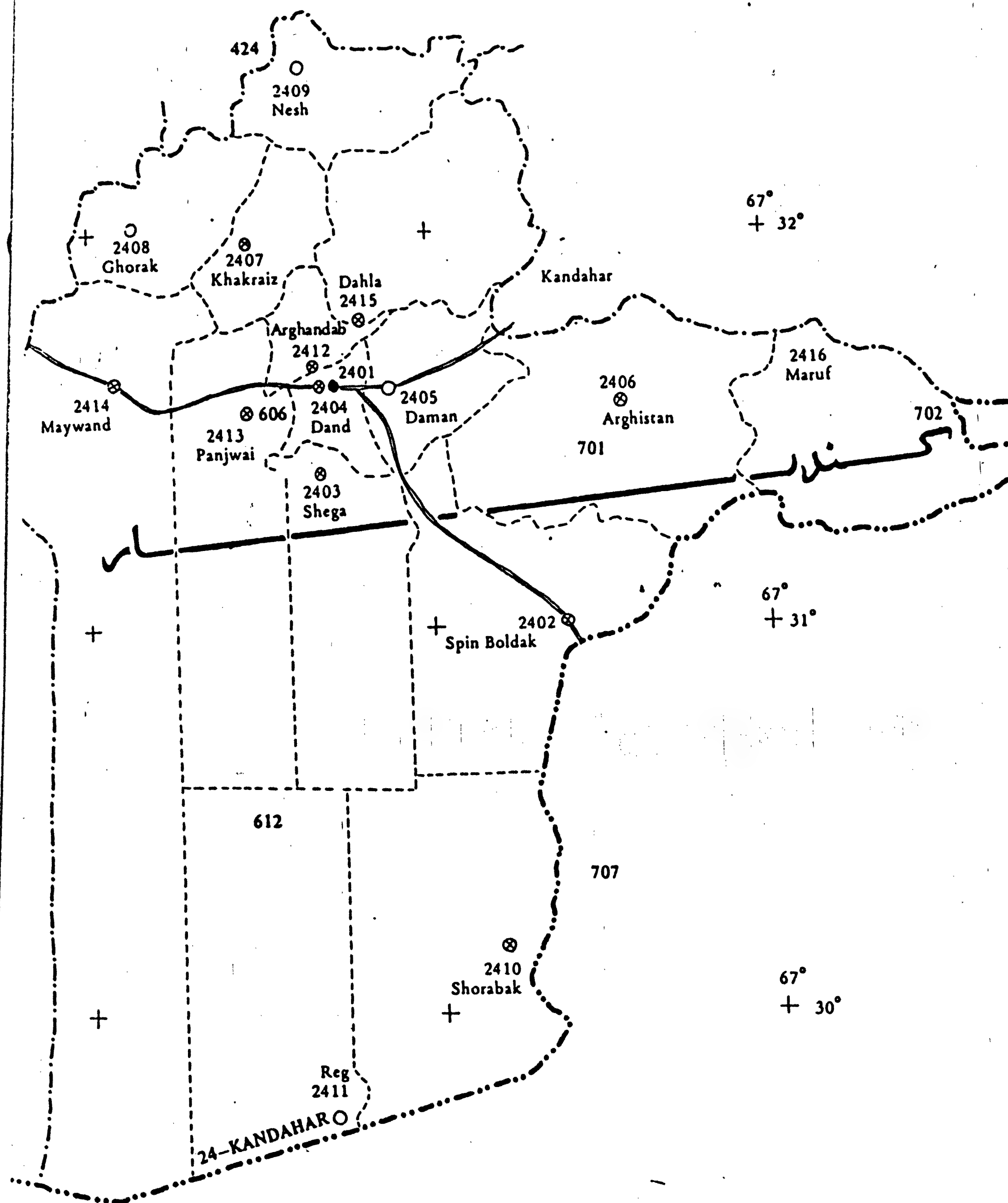
5. The Shura agrees for an extension of the existing clinic or new clinic. Particularly the provision of a female clinic with a female doctor. However, this female will not be allowed to stay within the SMU base with the other UN personnel. The shura will take all responsibility for her.

ANNEX V:

Pictures by WHO team:

1) IAHC clinic in Yousuf Kheil Arghestan- front view.
2) IAHC clinic in Yousuf Kheil Arghestan- view of freeze point.
4) IAHC clinic in Yousuf Kheil Arghestan- view of inpatient ward.
5) IMC clinic in Arghandab- side view.
6) IMC clinic in Arghandab- front view.
7) IMC clinic in Arghandab- inside.
8) IAHC clinic in Lala Malang Panjwai- front view
9) IAHC clinic in Lala Malang Panjwai- side view.
10) Military base clinic in Panjwai.
11) IAHC clinic in Lala Malang Panjwai- inside.
12) MCI clinic in Khasrub Arghandab
13) MSH Clinic in Arghandab big Mumara.
14) MCI clinic in Khujamulk Arghandab.
15) MCI clinic in Arghandab Dam
16) MCI clinic in Arghestan (mobile)- not mentioned in body of report.
17) MCI clinic in Arghestan (mobile).
18) MCI clinic in Khujamulk Arghandab.
19) IMC clinic in Khujamulk Arghandab.
20) LDI Al Jehad Clinic in Khujamulk Arghandab.
21) MSH clinic in Dand.
22) Students at madressa in Arghestan after WHO visit for health discussion.

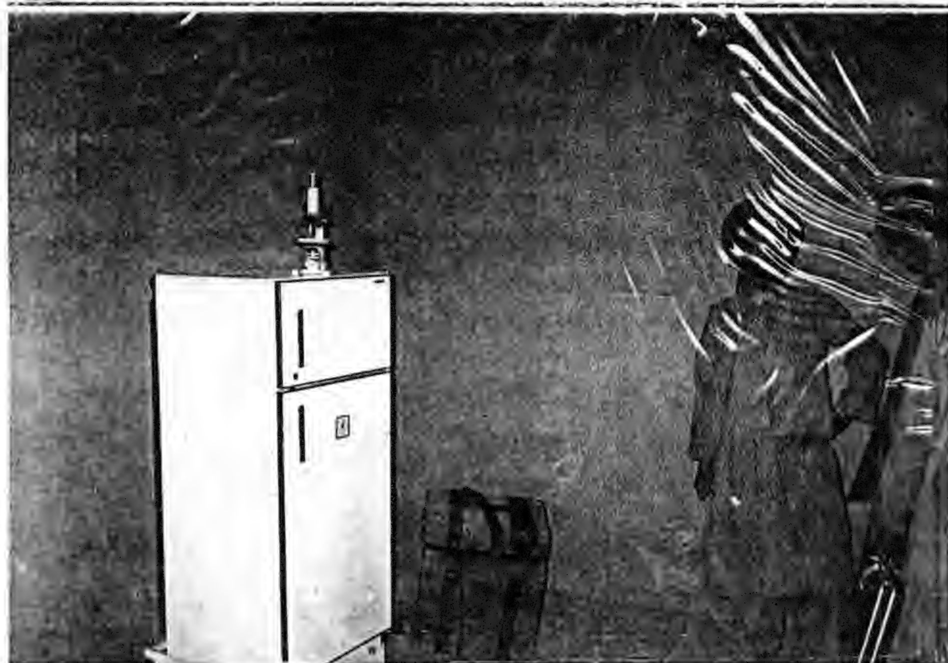
Administrative Divisions of Kandahar Province



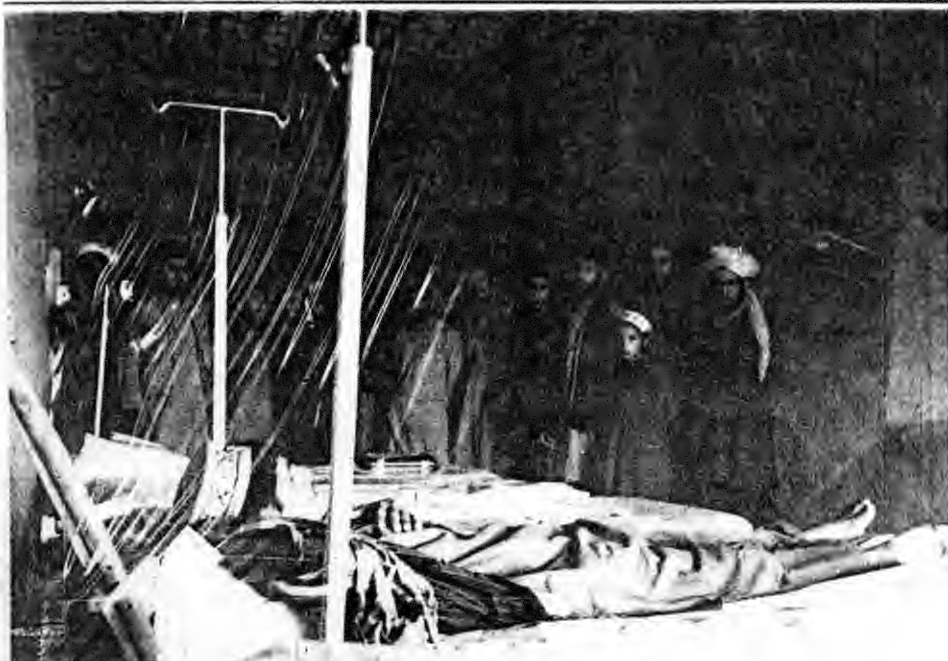
Source: Provisional Gazetteer of Afghanistan



IAHC CLINIC IN
YOUSUFKHAIL
ARGHESTAN
(Front view)



IAHC CLINIC IN
YOUSUFKHAIL
ARGHESTAN



IAHC CLINIC IN
YOUSUF KHAIL
ARGHESTAN



IMC CLINIC IN-
ARGHENDAB
(Lat. view)



IMC CLINIC IN
ARGHENDAB
(Front view)



IMC CLINIC IN
ARGHENDAB
(Inside view)



LALA MALANG HOSPITAL IN PANJWAI (Inside view)



MCI CLINIC IN KHUSRAB, ARGHENDAB



MSH CLINIC IN ARGHENDAB



MCI CLINIC IN KHUJAMULK, ARGHENDAB



MCI CLINIC IN ARGHENDAB DAM



MCI CLINIC IN ARGHESTAN (MOBILE)



MCI CLINIC IN
KHUJAMULK,
ARGHENDAB



IMC CLINIC IN
KHUJAMULK
ARGHENDAB



AL JEHAD CLINIC
(ARAB) IN
KHUJAMULK
ARGHENDAB

5. Mines have reportedly been cleared from Arghestan as of 31.08.90.

6. Community: The Shura of Arghestan was very helpful (especially Mullah Abdul Razaq). The shura represents two political factions (Hezbi-Hekmatyr and the Afghan Interim Government). In June a health committee was formed consisting of Shura leaders, health care workers and local leaders. This health committee was formed after discussion with WHO team members and was approved by the shura.

In annex IV the recommendations/requests of the shura regarding assistance by WHO specifically and the UN generally are stated. It is noteworthy that these requests are in some instances problematic for the UN in terms of their mandate and must be dealt with delicately.

In the early stages the WHO team member (male) attended some emergency patients but strictly avoided female patients in order to not create concern within the community. However, after a few days the Shura leader requested that services include some emergency female patients including a delivery. It was after this point that discussions were generated from the shura regarding the necessity for MCH (maternal-child Health) services. This was considered a significant change in attitude that should be carefully nurtured by the work of WHO and UNICEF over time.

Health Facilities

The establishment of the SMU clinic within the SMU base was deemed necessary for political reasons as well as the provision of health services not only for the SMU members but also the nearby villages. Placement in relation to the villages is reasonable. Previously the closest health facility to these villages was an MCI mobile unit with firstaid workers only (HIS #1673). The SMU clinic is approximately 10 km from the IAHC Arghestan clinic (or 1/2 hour journey by car).

The IAHC health facility in Arghestan in the village of Yousuf Khail (HIS #1059) was considered the highest level within the district. It was established in 1984 and functions as an OPD and is designed to provide mobile outreach services. In the initial stages it was planned for 10 inpatient beds and has occasionally had inpatient services available. The building itself is local construction (mud). Staff include 7 midlevel workers. WHO HIS database has many previous reports over the last few years of monitoring this facility by independent monitoring sources. It is reported that a project office was built in 1989. Immunization and TB programs were reportedly initiated in 1987. However, these services are not complete at the time of the visit. X-ray planned by IAHC report.
The IAHC program in the area was later associated with education and agricultural programs.



MSH CLINIC IN DAND



MADRASA/SCHOOL
IN ARGHESTAN



LALA MALANG
HOSPITAL IN
PANJWAI
(Front view)



LALA MALANG
HOSPITAL IN
PANJWAI
(LATERAL VIEW)



MILITARY BASE
CLINIC IN
PANJWAI

Arghandab

Travel from Arghestan to Arghandab takes approximately 3-4 hours via non-paved road. There was initially a mujahideen checkpoint there which made difficulties and after discussion within the political community this was stopped and travel since has been assisted.

The database had 68 health workers and 15 facilities listed in this district. Due to time and logistical constraints only 7 were visited. The choices of specific sites visited was based on accessibility to the team member while traveling through the area on the road.

Population figures are not known. According to UNIDATA the figures reveal 49,041 as estimated 1990 population.

The political/community authorities were very responsive to the WHO team. The primary representation is from Jamiat and NIFA parties. There has been no recent fighting within the area.

Mine clearing had been established via an NGO working in collaboration with UNOCA. Mine placement reportedly was on the hillsides rather than in the roads.

Referral of patients is to Quetta.

Health facilities:

1) An IMC clinic (HIS # 1183) is established in Chargulbah. The patients seen are primarily general medical. The villages around this health center are well populated but the location is not well situated in relation to the road. Travel to the clinic is not possible by vehicle. Recently one graduate physician has been placed in the clinic however, without support staff or drugs/equipment. Some people (? volunteers) are working here as assistants. This only brick made building seen in the entire area has 6 room latrine, water tank, electrical connection without generator. The community and political leaders expressed their support to upgrade this facility and to establish more regular services here including an MCH clinic, immunization programme. Additionally, WHO has been requested to arrange training and refresher training from this site. There were smaller health facilities working near this site supported by MSH and SCA. It has been reported in the past that these health workers have been working intermittantly within this facility since it's construction. This could provide ancillary workers for the health facility if the NGO's concerned can provide a model of cooperation and support for the health workers.

On discussion with IMC in Pakistan it is reported that the physician is being supplied now (September 1, 1990). Additionally, in their current training program there is 1 midlevel health worker selected from the area and one field microscopist who will join

is paved. At Spinboldek heading toward Arghestan the main Kandahar road may be used. However, after 20 km the road is under government control and for the remaining 90 kilometers into Arghestan alternative routes must be traveled which are muddy and mountainous.

The specific districts visited will be discussed in the following sections in relation to health inputs and resources. The use of the WHO questionnaire for each of the areas visited allowed an accounting of the situation at each site and is available upon request from WHO. In the final section are recommendations based on the information as observed on-site and from Pakistan. Annexes are included which contain the more detailed information. Within the context of the narrative report only those health facilities which are considered of highest quality within the district will be described.

Arghestan

WHO activities in Arghestan were initially related to assisting in the set up of the SMU. Direct patient care activities were provided in order to gather information about the health problems within the community and to provide a place for the interaction with health workers from other areas who were encouraged to visit. A sample of the health problems as seen within this "clinic" are included in Annex II. Additionally, a visit to a school was carried out in order to discuss with the headmaster the health problems of children.
Specific health workers and facilities as matched with the WHO HIS system are included sorted by district in Annex III.
The general points are brought out here:

1. Health Resources: Only two health facilities were reported in Arghestan according to the WHO Database of health facilities. This matched with what was actually found during the visit.

2. Population: There are 60 - 80 families in each of the 16 villages of the district. It is reported by the shura that one third of the population are refugees or internally displaced.

The internally displaced people come from mainly peaceful zones of other areas in Afghanistan and some refugees are from Pakistan.

3. Infrastructure: Arghestan is surrounded by mountains and communication to other places like Arghandab, Maruf and Zabul provinces is by non-paved routes. To reach the other districts of Kandahar is 3-4 hours journey.

4. Referral: Certain patients travel from both Zabul and Maruf to Arghestan which is a 4 hours drive to attend the IAHC clinic, Yousaf Kheil in Arghestan. Otherwise, referral to Pakistan via the route described above is utilized.

this facility upon graduation. IMC has decided that clinic #1024 discussed below will be discontinued and the worker will join the physician in the new health facility.

2. One MCI clinic in Khujmul (HIS #1799), is small (three rooms) but situated in an accessible and well populated place. The staff seem well trained based on observations. They requested more refresher training or any training under WHO supervision. Medicine and equipment are well supplied. Travel between Dand and Shahwalikot is good through non-paved road. Patients travel to this clinic from all over the area (some times many hours journey) thus, they have to stay over night in the village before returning home.

For the following districts only a very short time was available for the WHO team visiting. The information provided is by no means considered complete.

Punjwai

1. Islamic Aid Health Center (Lala Mullang Hospital) in Punjwai (HIS #1060).

It is a five room brick building situated in the center of Punjwai in an accessible and populated place. This is called a Hospital but currently functions as an OPD.

The staff are midlevel health workers. On observation of the staff, their patient register and their practices during diagnosis and treatment, the WHO team felt their training was of good quality. The drug supply is regular and well equipped. The Facility maintenance is good. The Shura leader of Punjwai appealed to WHO to establish an immunization programme, MCH center and retraining for staff. There is a laboratory which is running well but the other staff and the technician himself stated the need for more training. His skills at this time include only sputum smears for TB.

Khakreez:

1. On interview with one health worker who located the WHO team, there is reportedly a clinic in Khakreez run by 2 mid-level workers and a male nurse. The worker interviewed had a card stating graduation from the American institute in Peshawar. According to the worker there is no supply for the clinic. On questioning the staff member seemed well trained. It was stated that both mid-level health workers were trained in three years course from Kabul and Kandahar respectively.The health worker has a motorcycle. The Clinic is not situated near the road and due to time constraints the team was unable to visit the site. It is the recommendation by the WHO team that follow-up visit to this site be done to ascertain supply and functional capacity.

Dand

The team traveled through this area very quickly. It was possible to visit with certain community authorities and then one nearby clinic. Within the WHO database there are other facilities reported (see annex) but it was not possible to visit these.

Maiwand

As per above, the area was traveled very quickly. The WHO team was able to visit only two "health facilities". Neither of these are listed within the database because their staffing is Basic Health workers which by design are not placed in fixed locations.

Recommendations:

1. Since the grazing lands may not be demined (except Arghestan) at least in the initial stage, mine injuries are expected in Arghandab and Dand district.

2. The People and Shura are concerned about having health facilities and the quality of those that exist. It is considered a good sign that there was an awareness on the part of the authorities that refresher training is necessary and desireable. This will greatly assist such efforts in the future. However, the continued requests for the placement and support of new facilities while not addressing those existing is concerning.

Based on the opinion of the WHO team there are no new facilities needed in the areas visited in detail (ie Arghestan, Arghandab and Panjwai). In these areas the problem is not lack of health facilities but the poor quality and uncoordinated support for what does exist. Upgrading the quality of the existing structures and staff as well as expanding the services within these facilities is the first priority. This would by our assessment provide adequate health resources for a curative referral network upon which to then establish preventive and public health programs.
In the districts not visited due to time constraints (Dand, Khakreez, Maiwand) further evaluation must be carried out before further specific recommendations can be made.

WHO visits to an area for assessment/monitoring or evaluation must be assisted by improved logistical support. Multi-UN missions with short time frames hinder the ability to gather certain types of data which are necessary for planning. Follow-up visits to the areas which were traveled through only briefly is planned for further health resources assessment. These missions will likely be integrated with other terms of reference in order to bolster community support during the data gathering process. For example, nutritional surveys, training directed at health workers, distribution of materials.

The SMU clinic is planned by UNOCA for continued support in order to serve the villages and SMU operations. The hire of an Afghan physician to run this facility is planned by report of UNOCA. WHO involvement with local NGO's is recommended for orientation, technical support and ongoing supervision. The establishment of this clinic should not be outside the WHO mandate and activities in other areas of Kandahar. Assistance in supporting this person to carry out the functions of referral, training and supervision in the context of the other health facilities is critical. The guidelines for this persons activities as well as the selection has been set out within the WHO standardization program.
The "SMU clinic" should be coordinated with NGO inputs over time it is not likely that the UN will have longstanding interest in the salary of a physician in the rural health posts of Afghanistan. In the placement of this person the long term "system" to support the activities should be considered and initiated.

3. WHO can take an innovative and coordinating role in development of the Health system in Kandahar. Like many areas of Afghanistan there is a piecemeal "system" with components in place but not related to each other. The linking of available services both on-site and from the supporting agencies in Pakistan is possible and important. Kandahar currently represents an important area in that access is relatively easy for WHO staff. The frequent visits by technical personnel in order to provide on site training and supervision of health practices should be the goals of follow-up WHO missions.

Previously, WHO activities within Kandahar have involved the financial support of existing health facilities via NGO's. This should continue with feedback to the agencies involved regarding their activities. In the future WHO will begin more frequent visits within Kandahar to provide training modules. These training sessions are in response to the reports of every previous monitoring mission within Afghanistan (both NGO and UN) stating the need for refresher training and upgrading for health workers. The overall goal of is the strengthening the existing resources with gradual encouragement to incorporate PHC components.

4. The initiation of Maternal Child Health programmes can be considered in Arghestan, Arghandab and Punjwai but must be introduced in a diplomatic manner. Based on the behavior by the community leaders in Arghestan it is the feeling of the WHO field staff that the expectations of the shura leaders is unrealistic within the current circumstances. The placement of a female physician in the area it unlikely. Afghan female physicians or midlevel workers are rare and those trained would find the post very difficult both physically and culturally. It is the belief that such personnel if they were available should be situated with strong community support in areas where the MCH component has had more opportunity to mature.

Therefore, in this area MCH components should include the following:

a) Upgrading of existing male health workers in the topics of MCH via on-site and refresher training. This will be done by the provision of written materials on this topic for the various levels of health care workers. These materials can be distributed by WHO or NGO staff during on-site training or in Pakistan during refresher and resupply episodes.

It is particularly important that they become motivators for activities relating to MCH within their own communities. It is much the same as what occurred with the WHO team member whereby after winning the confidence of the community he was requested to begin seeing female patients. It is in many respects a training issue whereby both the health workers and the community must be given a model in which to become involved.

b) Provision of supply to health workers that is important to the preventable problems of women and children.

c) Technical support to agencies who have female health workers or programs that would be interested in placement within certain of the health facilities within Kandahar.

5. Immunization programmes can be started without delay in the IAHC clinics of Yousaf Kheil (Arghestan), IMC center in Arghandab and Lala Mullang clinic in Punjwai. Immunization was repeatedly requested by the community and is seen as a priority. In the IAHC Yousaf Kheil facility a fixed freeze point exists for the basis of such a program. Mobile teams based from this point would have access to all districts of Kandahar. They reported the presence of one trained vaccinator however, his presence was not confirmed after two visits. Clearly, more trained vaccinators would be needed to fulfill the goals of such a program.

Additionally, UNICEF and WHO can play an important role for the set up of immunization programmes based from some of the clinics in different districts which are well established and of high quality. For example, the facilities of IAHC in Arghestan and Panjwai and IMC in Arghandab.

The WHO teams concerns relate to the knowledge that inputs have been provided for EPI in Kandahar via UNICEF and NGO's (AVICEN and IAHC). What specifically has been developed by these inputs and the planning needs further investigation in Pakistan with the concerned agencies. Consultation with UNICEF initially is planned.

6. The location of the SMU base in Arghestan makes access to the other Kandahar districts more difficult. For follow up work via WHO Arghandab district may be more useful due to it's central location within the province and strong political/ community support for UN efforts,. Further work in Kandahar would be assisted if started from Arghandab.

7. The terms of reference included a monitoring function of a WHO

implemented program, the WHO-HIS database. It is the belief of the team members that the information provided by the field offices prior to the visit to Kandahar was very helpful. Overall, 70-80% of HIS information was correct but the fluid nature of the situation results in constant need of updating particularly via on-site monitoring. It is planned to consult the agencies whose clinics were visited about the findings on-site and the updating of information provided to WHO-HIS.

It has become obvious in working with the questionnaires and data returning from Afghanistan that teams or individuals crossing into Afghanistan need to understand how this data is used by the various agencies that rely on the reports of monitors. The linking of health workers names and numbers and health facility numbers is critical to an agency (whether WHO or an NGO). This implies that this data is understood and available to monitors. The orientation of data gathering teams is very important. It is unfortunate that too many times information is reported that cannot be acted upon simply because of the way it is reported.

8. Mobile clinics- These types of "clinics" or health inputs were initiated during the war in order to deal with trauma patients. In design these are first-aid workers with variable training (generally less than 3 months) who are following the active fighting. They are not supposed to be in fixed locations. Recently, these workers are found in villages functioning as OPD workers. It is most unfortunate for the groups supporting them that these workers represent them very poorly. The NGO's most at risk include SCA and MCI. During site visit, an assessment team will meet these types of workers and be told that they are supported by an agency and have multiple complaints regarding their support. Unless the assessment team is well oriented to the design and the history, the NGO appears to have a very low standard for health facilities. It is the belief of the WHO team that the design of first-aid mobile workers is no longer valid nor relevant. The supply and support of these workers takes resources away from other more useful facilities. It is the recommendation that the workers if proven reliable and interested be retrained to a more recognized level and placed near their home area in standard health facilities. Otherwise, support for this type of health input should be phased out over the next year.

9) Basic Health Workers- Currently these workers are functioning autonomously. This was not the intention of their training. What is unfortunate is that they most often introduce themselves and "doctors" and unless a team is oriented misunderstanding may occur. Additionally, these workers do not use available referral by higher levels of health care workers or facilities when they are available. Although these health workers have been placed by agencies in order to work within a village they seem most often to join together and become a type of health facility providing outpatient services. It is the goal in the future to begin to assist these workers to understand their limitations, their available referral within the areas they are working and to enhance

KANDAHAR

REPORT OF WHO ASSESSMENT MISSIONS

JUNE– AUGUST 1990

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